Written Statement for ACA Review Committee
AHIP Recommendations
Application of ACA Administrative Simplification Provisions to
Long-Term Care (LTC) Insurance Policies
June 16-17, 2015

We are pleased to provide written testimony on behalf of America's Health Insurance Plans (AHIP) specific to the LTC insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. Our industry processes millions of claims, eligibility requests, payments and other administrative and clinical transactions on a daily basis.

The key goal of the adoption of operating rules required by the ACA administrative simplification requirements is to reduce provider and health plan costs of routine administrative communications, such as providing information about insurance eligibility, the status of claims, payments, and payment statements. The HIPAA definition of a health plan includes many types of benefits that are very different from major medical health insurance plans. In the market today, consumers can purchase LTC insurance. While these types of policies are subject to the ACA requirements related to operating rules, we have conducted a thorough review of the operating rules and provide an analysis below on their applicability to these types of plans.

As part of the ACA Review Committee work, you are tasked with identifying specific standards and operating rules that are not meeting current industry needs and thus require a different standard or operating rules. We would support the Committee recommending that the currently adopted operating rules be designated as non-applicable to LTC insurance plans through an FAQ or other appropriate guidance and thus should not be part of the required health plan certification of compliance or attestation in the short term. In this testimony, we will demonstrate that the current data requirements do not match the process or coverage requirements that are utilized by LTC carriers. Requiring LTC carriers to spend substantial dollars and resources to support these operating rules that add very little value and are not supported by the providers only increase administrative costs for carriers (and ultimately to consumers) without a corresponding benefit of reduced administrative costs.

LTC carriers are not adverse to efforts to modernize and streamline administrative processing for long term care coverage. For the longer term, we recommend that the NCVHS Subcommittee on Standards or CMS convene future discussions with LTC providers and their respective trade associations and insurance providers regarding a long-term vision to automate transactions and develop standards that are more appropriate for the industry. AHIP and its member plans would be pleased to participate in these discussions with a number of our member companies.

Background

LTC insurance reimburses expenses for specific care to individuals who can no longer perform the day-to-day activities normally associated with independent living due to chronic illness, disability, or merely as a result of the frailties of aging, or who need supervision due to the presence of a cognitive impairment. Today, LTC services are provided primarily by home health care agencies and independent home health care providers. Other providers include assisted (residential) care facilities and nursing facilities. Excluded in most LTC insurance policies are hospitals, physicians, rehabilitation facilities and outpatient therapies which would be included in the individual's health insurance, Medicare or Medicaid coverage.

Section 1171(5)(G) of the Social Security Act (42 U.S.C. 1320d(5)) defines the term "health plan" for purposes of the administrative simplification rules as including a "LTC policy." As you know, the operating rules are designed to provide additional clarity to the existing HIPAA transaction standards and address certain business needs of providers to further automate their practices. In general, the early operating rules were not developed to accommodate non-medical lines of business and thus not all of them are applicable or effective. Below, we offer specific comments on each of the HIPAA standard and their associated operating rules and their applicability to LTC insurance.

Healthcare Claim

In preparing these comments, we asked AHIP member LTC insurance companies if they received electronic claims from providers. AHIP members who responded – representing majority of the LTC insurance market –indicated that they received zero electronic claims from providers. The nature of the provider population for LTC services is unlike that for health care generally, and includes care provided by nursing homes, assisted/residential care facilities, and home health care. These providers bill the care recipient or responsible individual directly, and it is very rare for these providers to submit electronic claims to LTC insurers. As such, LTC insurers very rarely receive claims from providers, pay providers directly, send providers ERAs or receive claim status inquiries. CMS acknowledged this in FAQ 8127[1] which asks if HIPAA transaction requirements, including the operating rules, apply to transactions between a health plan and its policyholders. CMS responded: "No, the HIPAA transaction requirements, including the operating rules, generally apply to electronic transactions between HIPAA covered entities. A covered entity is a health plan, a health clearinghouse, or a health care provider who transmits any health information in electronic form in connection with HIPAA transactions (45 CFR 160.103). Policyholders, patients, and members are not covered entities, and therefore are not subject to the HIPAA transaction requirements."

LTC insurers enter into policy contracts with individual consumers, not health care providers, and benefits under the policy are generally paid directly to the individual. In that circumstance, LTC insurers would not typically receive claims from the provider. There is minimal assignment of benefits to providers and most benefits are paid directly to the insured.

Eligibility

[1] https://questions.cms.gov/faq.php?id=5005&faqId=8127

Eligibility is not merely a matter of having a LTC insurance policy and a deductible. It is a complex, multi-stage, ongoing process. It often involves a physical demonstration of the insured's inability to perform Activities of Daily Living (e.g. determined by a face-to-face assessment). Depending on the insurer's claim processing model, medical records and physician diagnoses are not typically obtained.

The LTC insurance product presents unique challenges under the CORE operating rules primarily due to its uniqueness as a health plan "by definition," but a product that operates very differently than traditional or major medical health insurance. In fact, many would say that labeling LTC as "health insurance" is a misnomer. Health insurance operates on the presumption that based on medical necessity criteria, medical expenses will be reimbursed following satisfaction of a patient's financial co-insurance responsibility. The 270/271 eligibility transaction standard and related operating rules function under this same assumption. However, LTC insurance benefit eligibility does not follow this same model and in fact requires very different eligibility criteria process prior to benefit payment.

Health insurance is designed to address an acute episode requiring treatment; an accident, cancer treatment, a period of illness, etc. LTC insurance, on the other hand, never addresses a single acute episode. Instead, by design, LTC insurance only comes into play in cases of chronic ongoing disability, illness or disease. In fact, LTC is required under HIPAA and state insurance regulation to limit benefits to only those scenarios where an individual has satisfied defined benefit triggers. These benefit triggers are related to the individuals' ability to perform at least 2 activities of daily living such as bathing, dressing, or transferring for a period of at least 90 days or the individual requires substantial supervision to protect such individual from threats to health and safety due to "severe" cognitive impairment. The 270/271 transaction standard and data content operating rules do not contemplate any communication on this aspect of the LTC insurance eligibility process.

In addition, LTC insurance benefits are dependent on not only the individual's eligibility for coverage, but also the provision of specific LTC services by certain LTC providers, such as nursing homes, assisted living facilities, and home health care providers. Again this level of specificity is not provided in the 270 inquiry and/or the 271 response. Even the explicit service code inquiry doesn't allow for a meaningful 271 response as the vast majority of the required service type codes are not relevant to the coverage or, as in the case of home health care (code 42), do not provide enough provider detail to allow for a meaningful response, resulting in a 271 consisting primarily of zeros.

The 270/271 standard that mandates return of specific information relating to a patient's financial responsibility, such as the required data elements of co-insurance, deductible, and co-pay amounts, does not translate to the benefit model of a typical LTC insurance product. While most LTC insurance benefits do provide a cap on benefits; such as a daily benefit amount, or satisfaction of some prior patient co-insurance responsibility like a defined number of days in a facility at the patient's expense, these types of limitations do not fit into the 271 file layout definitions in a meaningful way. As a result, most inquiries simply return zeros or null values in these fields.

This lack of meaningful data content likely contributes to the other critical issue related to this standard- minimal provider utilization. With data content that is meaningless to a provider seeking to understand a patient's LTC insurance benefits and personal financial responsibility related to services, the 271 transaction in its current form fails. Providers simply do not utilize this EDI process. This lack of provider utilization is compounded by the fact that the majority of LTC insurance benefits are not assigned to providers, but rather reimbursable directly to the insured. This combination of meaningless data and the rarity of benefits assigned to providers results in a standard that brings no value to improved communication about insurance coverage and does nothing to address the goals of consistency or efficiency. That said, LTC and supplemental insurance carriers are required to invest substantial sums to meet these operating rule requirements, such as real time response, when the standard and operating rules do not help the carrier, the provider, or the insured.

An understanding of the uniqueness of the LTC insurance eligibility process needs to be considered in future rule development with input that allows for more effective communication of both meaningful patient financial responsibility elements as well as critical criteria that must be met before LTC insurance benefits are available. In addition, we would welcome a dialogue about addressing providers' low utilization of electronic transactions in the LTC insurance area.

PRIOR-AUTHORIZATION

The prior-authorization process is not relevant to LTC insurance.

CLAIMS STATUS

LTC insurers are required to provide claim status response 277 for pending claims upon provider request. However, providers are not utilizing this transaction and plans still need to support this transaction for LTC insurance and meet the infrastructure requirements associated with it to be in compliance with the standard and operating rules.

ERA/EFT

The rules were designed to aid providers in enrolling to receive the EFT and ERA, as well as help providers match up these two separate transactions. With these goals in mind, it is important to note that LTC insurance is very different from major medical insurance, because LTC insurers do not pay or reimburse physicians or hospitals. LTC insurers enter into policy contracts with individual consumers, not health care providers, and benefits under the policy are generally paid directly to the individual. In that circumstance, LTC insurers would not respond back with an ERA and EFT to a provider. In light of this lack of electronic claim submissions, and given the focus on administrative cost reduction, we believe it would not be the best use of resources to require compliance with the operating rules for a handful of transactions. There would be no associated benefit for either the providers (the intent of the operating rules) or consumers.

CMS acknowledged this when it drafted the EFT IFR's Regulatory Impact Analysis (D. Scope and Methodology of the regulatory Impact Analysis) which only addresses the costs and benefits of the operating rules with respect to two types of providers – hospitals and physician practices – and comments that there was "very little data on the adoption rate or usage of the health care electronic funds transfers (EFT) and remittance advice transaction among pharmacies, dentists,

suppliers of durable medical equipment, nursing homes, and residential care facilities." The analysis further acknowledges that "the lack of data for these types of health care providers has been noted in other studies on administrative simplification" and assumes that "hospitals and physician practices, which receive the majority of health care claim payments, stand to gain the greatest benefits." [2]

Direct consumer payments are neither addressed in the in the interim final rule adopting the EFT standard (77 Fed. Reg. 1556) nor in the remittance advice transaction as defined in 45 CFR §162.1601.[3]

As mentioned in Panel 2, the LTC insurance product does not fit easily into the current EDI transaction standards or operating rules. The product does not operate like "health insurance" and requires a significant level of additional detail to adjudicate a claim. This includes assessing the individual's eligibility for coverage as well as the ensuring that the nature of the services and providers involved in the individual's care are LTC specific. In addition, because there is minimal assignment of benefits to providers, most benefits are paid directly to the insured. The end result is that utilization of the standards by providers is almost nonexistent within the LTC insurance segment.

These same challenges extend to the transactions related to remittance advice and the related 835, particularly in terms of the CARC/RARC codes required under Rule 360. The current Rule 360 CARC/RARC combinations lack the clarity to give providers a meaningful explanation of benefit adjudication decisions. For example, in a recent comparison of print EOB remark codes to CARC/RARC codes for one of our LTC carriers, more than 40% of the current EOBs were mapped to CARC/RARC codes indicating that "additional information would be sent separately." In most of these scenarios, the print EOB provided far more relevant detailed adjudication information then the limited information provided in the data content. The LTC insurance industry struggles with the value of the standard where it functionally is just communicating to the provider to wait for more information or reach out to the carrier directly. In addition, the LTC segment would benefit from additional guidance on the correct interpretation of existing CARC/RARC codes combinations as they relate to LTC insurance adjudication, particularly CARC 246.

A more fundamental concern is that there is no ability to address within the data mechanism an explanation to providers on the dependencies related to the insured's eligibility for LTC services. The resulting communication therefore, does not achieve the standards' goal of improved efficiency and simply adds an additional step that is not meaningful to any of the parties involved. An understanding of the uniqueness of the LTC insurance claim adjudication process needs to be considered in future rule development with input that allows for more effective communication of claims adjudication scenarios and codes.

Conclusion and Recommendations

[2] See 77 FR 1580

[3] EFT and ERA is defines the health care as the transmission of any of the following from a health plan to a health care provider: (1) Payment; (2) Information about the transfer of funds; (3) Payment processing information and either the explanation of benefits or remittance advice.

We would support the Committee recommending that the currently adopted operating rules be designated as non-applicable to LTC insurance plans through an FAQ or other appropriate guidance and thus should not be part of the required health plan certification of compliance or attestation in the short term.

For the longer term, we recommend that the NCVHS Subcommittee on Standards or CMS convene future discussions with LTC providers and their respective trade associations and insurance providers regarding a long-term vision to automate transactions and develop standards that are more appropriate for the industry. AHIP and its member plans would be pleased to participate in these discussions with a number of our member companies.